

ACTION AGAINST AIDS: A Legacy of Leadership At Home and Around the World



A Report to the President from
The White House Office of National AIDS
Policy

World AIDS Day
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EXECUTIVE SUMMARY

As we commemorate World AIDS Day 2000, we reflect on the accomplishments of the past eight years and the challenges that lie ahead in the war against HIV/AIDS, both at home and abroad. The toll taken by this disease is high, but we are making progress.

Since the epidemic began in 1981, more than 700,000 Americans have been diagnosed with AIDS, and more than 420,000 men, women, and children have lost their lives to the disease. An estimated 800,000 to 900,000 Americans are now believed to be living with HIV. Each year, 40,000 Americans become infected with HIV – more than 110 a day. Half of new HIV infections in the U.S. are estimated to occur among young people under the age of 25. In 1993, more than 45,000 people died from AIDS and its complications. Since then, advances in HIV treatments have led to dramatic declines in AIDS deaths.

The Clinton-Gore Administration has taken aggressive steps to combat HIV/AIDS, including:

- More than doubling spending on research, prevention and treatment government-wide since 1993, to a total of more than \$12 billion in FY 2001;
- Taking strong steps to eliminating racial and ethnic disparities in HIV and AIDS;
- Strengthening the Ryan White CARE Act, which provides treatment to 500,000 people with HIV and AIDS nationwide;
- Leading the search for an AIDS vaccine with the largest single vaccine research program worldwide;
- Accelerating AIDS drugs approvals; and
- Enabling individuals with HIV and AIDS to become and stay competitively employed through the Ticket to Work and the Work Incentives Improvement Act.

In addition, the Clinton-Gore Administration established the White House Office of National AIDS Policy; created the Office of AIDS Research and the Vaccine Research Center at NIH; convened the first White House Conference on HIV/AIDS; and established the Presidential Advisory Council on HIV/AIDS.

These efforts, combined with new drugs, new treatment guidelines, new alliances, and increased access to AIDS care and support, have resulted in real progress. The National Center for Health Statistics announced in October 1999 that HIV/AIDS mortality has declined more than 70% since 1995, and new infections resulting from mother-to-child transmission have declined by 75%. In 1996, for the first time in the history of the AIDS epidemic, the number of Americans diagnosed with AIDS declined. AIDS deaths dropped 20% between 1997 and 1998. Today, AIDS cases are no longer among the top 15 causes of death, a fall from 8th place in 1996. Overall, the age-adjusted death rate from HIV infection is the lowest since 1987. However, the number of new AIDS cases among women, minorities, and adolescents has increased considerably, indicating that the need for effective, well-targeted prevention efforts is still crucially important, and increased access to health care remains essential, as does the search for more and better treatments and a vaccine.

Globally, the statistics are even more staggering. In nearly two decades of AIDS, HIV has infected 57 million men, women, and children worldwide – and that number is projected to reach 100 million by 2005. Nearly 22 million people have died of AIDS, with 3 million deaths occurring just last year. Over 13 million children under 15 have lost one or both parents to AIDS, and the total number of AIDS orphans is expected to exceed 40 million by 2010. HIV/AIDS is now the 4th leading cause of death worldwide and the single leading cause of death in sub-Saharan Africa. Over 36 million people around the world are living with HIV – often suffering in silence with little or no access to even basic care and support.

We have made inroads in the global fight against HIV/AIDS as well, including:

- Helping to reduce HIV prevalence in young adults in Uganda and Zambia, and maintaining low prevalence rates in Senegal, Philippines, and Indonesia;
- Pioneering voluntary HIV testing and counseling in Africa;
- Launching International HIV/AIDS Alliance and helping to create UNAIDS;
- Establishing a government-wide global AIDS effort which includes the active involvement of all White House offices, USAID, the Departments of Health and Human Services, Labor, Defense, State, Treasury, and Commerce, the U.S. Ambassador to the United Nations, and the Peace Corps;
- Appointing a first-ever Presidential Envoy for AIDS Cooperation and encouraging other countries to do the same; and
- Expecting to more than triple our global AIDS funding, and continuing to leverage additional resources from other donors and sectors.

In spite of these accomplishments, our work is far from over. UNAIDS has projected an annual global funding gap of \$2.5 billion for Africa alone, and \$1.5 billion for the remainder of the world. As a global community we need to move aggressively to close this gap. And the United States, as a leader in this fight, must continue to be focused and out front in this important cause.

I. AIDS in America

“The epidemic in the U.S. is far from over. With more than 40,000 new infections each year -- it is increasingly women, young people, and people of color who are caught in the crossfire. Complacency is now our biggest enemy.”

Debra Fraser-Howze
President and CEO, National Black Leadership Commission on AIDS

Today, an estimated 800,000 to 900,000 Americans are believed to be living with HIV (Human Immunodeficiency Virus), the virus that causes AIDS (Acquired Immune Deficiency Syndrome). Since the epidemic began in 1981, more than 700,000 Americans have been diagnosed with AIDS, and more than 420,000 men, women, and children have lost their lives to this disease.

The Clinton Administration has responded aggressively to the significant threat posed by HIV/AIDS with increased attention to research, prevention, and treatment. Overall funding for AIDS-related programs within HHS has increased by approximately 130% under the Clinton Administration, with funding for HIV/AIDS care under the Health Resources and Services Administration’s Ryan White CARE Act increasing by 373%. In FY 2001, the Administration expects to spend \$9.5 billion on HIV/AIDS within HHS.

At the same time, the Administration has sharpened the focus of its AIDS programs, establishing a new Office of National AIDS Policy (ONAP) at the White House, and signed legislation creating a permanent Office of AIDS Research at the National Institutes of Health (NIH). The Administration also convened the first-ever White House Conference on HIV and AIDS in December 1995, released the first National AIDS Strategy in December 1996, and prepared the first federal biomedical research plan for HIV/AIDS in 1997. In May 1997, President Clinton announced a comprehensive AIDS vaccine research initiative designed to lead to the development of an AIDS vaccine within 10 years, and in 1998, the Food and Drug Administration approved the nation’s first large-scale trial of an AIDS prevention vaccine. In addition, the President announced the Millennium Vaccine Initiative on May 31, 2000 which calls for sharp increases in vaccine research at the National Institutes of Health, new investments for the purchase and delivery of existing vaccines, and a substantial tax credit for the private sector to speed the development of new vaccines.

Today, HIV research efforts are making real inroads. New drugs are providing vast improvements in the treatment of HIV and AIDS, and new treatment guidelines released by the Department of Health and Human Services (HHS) are giving health professionals much-needed guidance to help standardize the care of individuals living with HIV/AIDS. As a result, the National Center for Health Statistics announced on October 5, 1999, that HIV/AIDS mortality has declined more than 70% since 1995, and that AIDS cases are no longer among the top 15 causes of death in national statistics – a fall from 8th place in 1996. *Overall, the age-adjusted death rate from HIV infection is the lowest since 1987.* This reflects the impact of powerful new

HIV drugs and increased access to health care for those living with HIV/AIDS. However, transmission of the disease continues, and effective prevention efforts – including the search for a vaccine – are still crucially important.

The trends in AIDS death rates are uneven across racial and ethnic groups. In October 1998, President Clinton declared HIV/AIDS to be a severe and ongoing health crisis in racial and ethnic minority communities and announced a comprehensive new initiative in collaboration with the Congressional Black Caucus to improve the nation's effectiveness in preventing and treating HIV/AIDS in the African-American, Hispanic, and other minority communities. Through the Minority AIDS Initiative, targeted funding and technical assistance helps minority organizations and coalitions become stable, ongoing sources of HIV prevention, HIV care and treatment services, and substance abuse and mental health services within their communities. In June 1999, the Administration announced that Crisis Response Teams would provide special technical assistance to 11 U.S. metropolitan areas to combat the spread of HIV/AIDS among racial and ethnic minority populations. The Crisis Response Teams are meeting with local officials, public health personnel, and community-based organizations that work with racial/ethnic minority persons living with HIV/AIDS to help them develop targeted strategies to curb the rapid spread of HIV/AIDS among minority populations in their communities and to encourage those affected to enter care.

II. Record of Progress

"After years of silence...the Clinton Administration has been a clear, strong, and tireless voice for people living with HIV/AIDS."

Jamie Fox
Executive Director, AIDS Action

In 1993, more than 45,000 people died from AIDS and its complications. Since then, advances in HIV treatments have led to dramatic declines in AIDS deaths. In 1999, the number of deaths attributed to AIDS dropped to just over 16,000. In addition, the U.S. has seen dramatic reductions in mother-to-child, or perinatal, HIV transmission rates. In 1993, 873 cases of perinatal transmission were reported, but by 1998, this number had dropped to 224. And since 1997, the annual number of new AIDS cases has declined by more than 13%, from 49,676 in 1997 to 42,697 in 1999.

A. INCREASING DOMESTIC SPENDING ON HIV/AIDS

Under the Clinton Administration, discretionary spending for HIV/AIDS research, prevention, and treatment has increased dramatically. Altogether, discretionary AIDS-related spending by HHS in FY 2001 will likely total \$5.2 billion, up from \$2.1 billion in FY 1993. In addition, at least \$4.3 billion is estimated to be expended in FY 2001 for AIDS care under Medicaid and Medicare, up from \$1.6 billion in FY 1993. It is estimated that more than 50% of Americans living with AIDS rely on Medicaid for their health coverage.

In FY 2001, we expect an increase of \$186 million, for a total of \$916 million, for programs focused in two areas – domestic HIV prevention and global AIDS. This increase in funding for HIV activities at the Centers for Disease Control and Prevention (CDC) will be used to encourage at-risk individuals to avoid behaviors that can result in the transmission of the disease. Funding for CDC HIV prevention efforts in the U.S. has increased by \$418 million, or 84% during the Clinton Administration.

In FY 2001, we will likely invest an additional \$228 million over FY 2000, for a total of \$1.83 billion, in the Ryan White CARE Act Program, an increase of almost 14% over last year's funding level, to provide primary medical care and other crucial support services for people living with HIV and AIDS among increasingly vulnerable populations. This increase will allow an additional 7,300 persons to receive drug therapy through the AIDS Drug Assistance Program. These drugs have helped to decrease the progression of HIV to AIDS as well as to improve the quality of life for people living with HIV/AIDS. During the Clinton Administration, the funding for the Ryan White CARE Act has increased 373% from \$385 million in FY 1993 to an estimated \$1.823 billion in FY 2001.

In FY 2001, we will likely spend a total of \$2.1 billion for AIDS-related research at the NIH. This is an increase of \$105 million, or 5.2% over the FY 2000 level. It represents a 97% increase in funding for NIH AIDS-related research since FY 1993.

Further, the Administration expects to spend \$161 million for the Substance Abuse and Mental Health Services Administration (SAMHSA) to address substance abuse and mental illness specifically as they relate to HIV/AIDS. This is an increase of \$51 million, or 46% over the FY 2000 level. The majority of this funding will be used for the HIV set-aside of the Substance Abuse Block Grant and Targeted Capacity Expansion programs for substance abuse treatment, prevention, and HIV/AIDS services focused on building infrastructure in racial and ethnic minority communities highly impacted by the HIV/AIDS epidemic.

B. STEPPING UP PREVENTION

HIV prevention efforts in the United States have significantly reduced the incidence of HIV infections. Prevention initiatives have helped slow the rate of new HIV infections in the U.S. from more than 150,000 per year in the late 1980's to approximately 40,000 per year today. Specifically, the number of U.S. infants who acquire AIDS from mother-to-child transmission dropped by 75% from 1992 to 1998. In 1996, for the first time in the history of the AIDS epidemic, the number of Americans diagnosed with AIDS also declined. AIDS deaths dropped 42% between 1996 and 1997, and the rate of decline was 20% from 1997 to 1998.

- **Helping Communities**

CDC provides communities with extensive financial support and technical guidance to implement effective strategies to prevent HIV transmission. Each year, CDC delivers more than \$450 million in financial support for HIV prevention activities to 65 state, territorial and local health departments, multiple national and regional minority organizations, and more than 100 local community-based organizations. Altogether, this assistance accounts for 76% of CDC's spending on HIV prevention for high-risk communities.

In 1993, CDC revised the way funds were distributed from health departments, adopting "community planning" to improve the effectiveness of its prevention funding to local communities. Under this approach, special committees, including health department and community representatives, collaborate to determine local priorities for HIV prevention based on data on the local epidemic, existing community resources, and science on the most effective prevention interventions.

In addition to community-based prevention programs, CDC grants to health departments also support the public HIV counseling and testing programs that serve as a gateway to HIV prevention and treatment for both at-risk and infected individuals. CDC also funds and provides technical assistance to state and city education departments throughout the country to help them provide HIV prevention education for young people.

- **Published Interventions to Assist in HIV Prevention**

CDC developed the *Compendium of HIV Prevention Interventions with Evidence of Effectiveness* to help prevention service providers, planners, and others to implement science-based interventions that work. The *Compendium* provides state-of-the-science information about interventions with evidence of reducing sex- and/or drug-related risks and the rate of HIV/STD infections. These interventions have been effective with a variety of populations, including heterosexual men and women, high-risk youth, incarcerated populations, injection drug users, and men who have sex with men. All interventions included in the *Compendium* came from behavioral or social studies that had both intervention and control or comparison groups and had positive results for behavioral or health outcomes.

- **Implemented the *Know Now!* Campaign**

Of the estimated 800,000-900,000 people living with HIV in the U.S., as many as one-third don't know it. Experience with and formal evaluations of previous public health social marketing and communication campaigns consistently demonstrate the value of communication approaches in increasing awareness and promoting specific behaviors, such as HIV testing. In addition, campaigns can play a significant role in addressing HIV related stigma. For these reasons, CDC has developed "Know Now!," a social marketing campaign that will utilize various communication channels in multiple targeted efforts to reach those at greatest risk of HIV with HIV testing and referral messages.

- **Helping with HIV/AIDS Surveillance**

CDC works with state and local health departments to track the number of HIV and AIDS cases in different areas. In December 1999, after extensive work with state health departments and community HIV/AIDS organizations, CDC released guidelines to assist states in designing and implementing effective HIV surveillance systems. These guidelines include specific standards for both quality and confidentiality, reflecting CDC's responsibility to balance the need for better data with legitimate concerns about confidentiality and security. They also stress the continued importance of anonymous testing as an essential component of any surveillance system.

- **Promoting Collaboration for Incarcerated Populations**

The prevalence rates for AIDS are significantly higher among inmates and releasees – especially women and adolescents – than in the total U.S. population. Of the estimated 229,000 persons living with AIDS in 1996, almost 39,000 (17%) passed through a correctional facility that year. The confirmed AIDS case rate among prisoners (0.51%) was more than 5 times the U.S. rate. Racial and ethnic minorities are disproportionately represented in incarcerated populations, and approximately 80% of prisoners have a history of substance abuse, including alcohol use. To begin to address these issues, in FY 1999, CDC and the Health Resource and Services Administration (HRSA) jointly developed and funded a corrections demonstration project with 7 state health departments to design and implement innovative HIV prevention, care, and continuity-of-care programs for inmates in jails, prisons, or juvenile detention centers. Projects were also funded to provide technical support for these demonstrations and help highly impacted communities develop capacity to address HIV/AIDS prevention in correctional settings.

- **Making Progress With Associated Conditions**

Syphilis infections increase the risk of HIV transmission among adults at least 3- to 5-fold. Since 1990, syphilis rates have declined 88%. In 1999, CDC launched the *National Plan to Eliminate Syphilis in the United States* and initiated new efforts targeting 33 states and cities with either a heavy burden of syphilis or a high potential for re-emergence of syphilis. CDC has also increased tuberculosis (TB) prevention and control activities, and subsequently reported a 34% decrease in new TB cases in the U.S. from 1992 to 1999. Persons with weakened immune systems, especially those infected with HIV, are at higher risk of developing active TB once infected with TB.

- **Developing New Testing Technologies**

CDC developed a cutting-edge laboratory tool, the detuned assay, which allows identification of recent HIV infections. This new technology has enhanced our ability to characterize the epidemic and allows us to ensure prevention programs are directed to those most in need.

- **Engaging States in Prevention**

SAMHSA has encouraged state and community efforts to link and coordinate substance abuse treatment, mental health services, and HIV/AIDS prevention and treatment efforts. SAMHSA surveys, conducted with the three national state mental health, alcohol and substance abuse organizations, identified gaps in service coordination and ways to enhance service integration at the state level. These data are informing states on ways to bridge the three communities to improve outcomes for people with or at risk for substance abuse, mental illness and/or HIV/AIDS.

- **Reducing Risk-Taking Behavior**

SAMHSA's Center for Mental Health Services (CMHS) funds Project Shield, the HIV/AIDS High-Risk Behavior Prevention/Intervention Model for Adolescents/Young Adults and Women Program. Project Shield is a four-year, multi-site effort which is developing, implementing and evaluating a community-focused intervention to reduce high-risk behaviors among individuals at high risk for HIV infection.

- **Informing Communities on Syringe and Needle Exchange Research**

Scientific research supported by NIH has shown that needle exchange programs can be an effective component of a comprehensive strategy to prevent HIV and other bloodborne infectious diseases in communities that choose to include them, and do not encourage the use of illegal drugs. The Clinton Administration has communicated what has been learned from the science so that local communities can construct the most successful programs possible to reduce the transmission of HIV, while not encouraging illegal drug use.

- **Supporting Substance Abuse Treatment Services**

More than one-third of all AIDS cases are directly or indirectly attributable to substance abuse. Current evidence indicates that substance abuse treatment greatly reduces risk behaviors

associated with the transmission of HIV. Beginning in 1994, SAMHSA's Center for Substance Abuse Treatment (CSAT) has supported the AIDS Outreach Program (now called the Community-based Substance Abuse and HIV/AIDS Outreach Program) targeting high-risk injecting drug users, designed to both increase the number of clients entering treatment and to reduce their risk for contracting HIV and other infectious diseases. In FY 1999, SAMHSA initiated a Targeted Capacity Expansion Program for Substance Abuse Treatment and HIV/AIDS Services in racial and ethnic communities with high AIDS case rates, expanding this effort to include a second group of grantees in FY 2000 with a total investment of \$32 million. In addition, SAMHSA's Substance Abuse Prevention and Treatment Block Grant HIV set-aside provides funds for HIV counseling and testing in states with high AIDS case rates.

C. IMPROVING ACCESS TO CARE AND TREATMENT

- **Administering the Ryan White CARE Act**

HRSA's HIV/AIDS Bureau administers the Ryan White CARE (Comprehensive AIDS Resources Emergency) Act, enacted in 1990 to provide primary care and supportive services for low-income, uninsured and underinsured individuals and families affected by HIV/AIDS. Since FY 1991, \$8 billion has been appropriated for CARE Act programs, with a 373% increase in funding during the Clinton Administration (FY 1993-FY 2001). In 2000, the CARE Act is serving some 500,000 people, providing care for individuals affected by HIV/AIDS in every state, the District of Columbia, Puerto Rico, Guam, and the Virgin Islands. The CARE Act also funds services to individuals in 51 major metropolitan areas hardest hit by the AIDS epidemic. More than 2,500 organizations are now receiving funding to provide care to individuals living with HIV disease in their communities.

The CARE Act has saved many lives by speeding delivery of new HIV/AIDS treatments to the many Americans who otherwise lacked access to these therapies and quality health care. In 1995, AIDS was the leading cause of death for Americans between the ages of 25 and 44. In 1996, highly effective new HIV/AIDS medications were introduced, and the AIDS Drug Assistance Program (ADAP) began to assist the states in paying for the expensive new medications. The benefits of these therapies were seen in 1997, when a sharp drop in the AIDS mortality rate was reported. In FY 2001, the Clinton Administration expects to spend \$594 million for the ADAP program, which serves thousands of Americans who would otherwise go without life-sustaining HIV/AIDS medications.

On May 26, 1996, and again on October 20, 2000, President Clinton signed legislation reauthorizing the Ryan White CARE Act for another five years. In addition to the health care and pharmaceutical assistance provided through states and municipalities described above, the CARE Act supports 260 programs that provide community-based HIV early intervention services, including HIV testing and counseling, and treatment for HIV disease. Over 700,000 AIDS care providers have received state-of-the-art education and training through the AIDS Education and Training Centers Program.

By widely distributing the results of the 076 AZT Perinatal Transmission Study to CARE Act providers, HRSA has facilitated a dramatic nationwide reduction of mother-to-infant transmission of HIV, with the incidence of mother-to-child transmission dropping to nearly zero

at many treatment centers funded by the CARE Act. Through the Special Projects of National Significance Program, more than 200 research and demonstration projects nationwide have been supported to develop and evaluate new and more effective ways to delivery HIV/AIDS care and services to hard-to-reach populations.

- **Providing Mental Health Services**

Attention to the mental health needs of persons living with HIV, or those with high-risk behaviors for HIV infection, is critical to HIV prevention and treatment efforts. CMHS funded the Mental Health Services Demonstration Program from FY 1994-FY 1998 to provide mental health services to people living with or affected by HIV, to generate new knowledge about the role of mental health services in primary medical treatment for people living with or affected by HIV, and to identify characteristics of clients served and types of services utilized. CMHS now sponsors a collaborative effort with CSAT, HRSA and three NIH institutes, known as the HIV Cost Study Grant Program, to determine the effectiveness of treatment adherence models, health outcomes, and costs associated with the provision of integrated mental health, substance abuse, and HIV/AIDS primary care services for people living with HIV/AIDS who have both a mental disorder and a substance abuse disorder.

- **Offering Treatment Guidelines**

HHS regularly updates and releases clinical guidelines for treating HIV disease using antiretroviral drugs among adults and adolescents, women during pregnancy, and children and infants, and guidelines for the reduction of mother-to-child transmission of HIV. The guidelines, developed by panels of AIDS clinicians and researchers, reflect the current state of knowledge about HIV disease and antiretroviral drugs, and help to improve and standardize the quality of care for HIV-infected persons in the U.S.

- **Approved Maine Medicaid Demonstration Plan**

On February 24, 2000, HHS approved Maine's Medicaid demonstration plan to launch an early intervention and treatment program for individuals in need who are HIV-positive but do not yet have AIDS and who are not already eligible for Medicaid. Maine is the first state to offer a plan to enroll low-income HIV-positive individuals in the Medicaid program before they become disabled or impoverished. Recent research has shown that early intervention with AIDS-fighting drugs, including antiretroviral therapies, can slow the progress of the disease and increase life expectancy for many HIV-positive individuals. However, many people with HIV generally do not qualify for Medicaid – the state/federal partnership that provides health insurance to low-income young, aged, blind and disabled Americans – until they are considered disabled. This demonstration program will make drug therapies and treatment services available to HIV-positive people earlier in the course of their disease, helping them live longer, healthier lives.

- **Advancing Goals of Ticket to Work and Work Incentives Improvement Act**

On October 25, 1999 HHS announced two new initiatives to enable people with disabilities to become and stay competitively employed. One of the grant programs will fund cutting-edge demonstrations that enable people with chronic, disabling conditions to get medical benefits without having to quit their jobs to obtain needed care. The other will assist states to increase

services and supports to those who work, as well as help others return to work without the fear of losing health coverage. Both the grants and the demonstrations help advance the goals of the Ticket to Work and Work Incentives Improvement Act of 1999, a law passed by the Congress and strongly supported by the Clinton Administration to encourage people with disabilities to work without fear of losing their Medicare, Medicaid or similar health benefits. For example, Mississippi is using its \$27.5 million grant award with additional state funds to cover 500 persons with a diagnosis of HIV/AIDS who work or who plan to return to work. The state's program will mirror the full Medicaid benefits and services. The project is being implemented in nine counties in the Mississippi Delta where there is a relatively high rate of HIV/AIDS and limited health care resources for people with HIV/AIDS.

- **Accelerating AIDS Drug Approvals**

Since 1993, the Food and Drug Administration (FDA) has approved 11 AIDS drugs and 22 new drugs for AIDS-related conditions, and accelerated approval to record times. Included in those approvals were the new class of drugs known as protease inhibitors, which have proven to be dramatically effective in the treatment of HIV disease. In March 1997, the FDA approved the first protease inhibitor with labeling for use in children. Also in 1997, the President signed into law the FDA Modernization Act that included important measures to modernize and streamline the regulation of biological products; increase patient access to experimental drugs and medical devices; and accelerate review of important new medications. These reforms build on the Administration's Reinventing Government initiatives which led U.S. drug approvals to be as fast or faster than any other industrialized nation. Average drug approval times have dropped from almost three years at the beginning of the Clinton Administration to just over one year.

- **Administering the Ricky Ray Hemophilia Relief Fund**

In August 2000, HHS began notifying the first eligible families approved to receive payments from the Ricky Ray Hemophilia Relief Fund. The fund was authorized by Congress in 1998 to provide compensation payments of \$100,000 to individuals with blood-clotting disorders, such as hemophilia, who contracted HIV from contaminated anti-hemophilic blood products between July 1, 1982 and Dec. 31, 1987. Spouses and children who contracted HIV from these individuals and certain survivors may also be eligible. In 1999, the Clinton Administration worked with Congress to achieve a \$75 million appropriation for FY 2000, and in FY 2001 the President committed to fully fund the balance of the \$750 million authorized for the Trust Fund.

D. ACCELERATING RESEARCH

The NIH represents the largest single public investment in AIDS research in the world. NIH funding for AIDS research has nearly doubled during the Clinton Administration, increasing from \$1.1 billion in FY 1993 to \$2.3 billion in FY 2000. The NIH supports a comprehensive program of basic, clinical, and behavioral research on HIV infection and its associated opportunistic infections and malignancies, including a growing portfolio of research conducted in collaboration with investigators in developing countries. This research aims to better understand the basic biology of HIV, develop effective therapies to treat it, and design interventions to prevent new infections from occurring.

- **Office of AIDS Research**

In one of his first acts in office, President Clinton signed the National Institutes of Health Revitalization Act of 1993, placing full responsibility for planning, budgeting and evaluation of the AIDS research program at NIH in the Office of AIDS Research (OAR). Since 1993, OAR has developed an annual comprehensive AIDS research plan and budget, based on the most compelling scientific priorities that will lead to better therapies and prevention for HIV and AIDS. These priorities are determined through a unique and collaborative process involving the 25 NIH institutes and centers and non-government experts from academia and industry, with the full participation of AIDS community representatives.

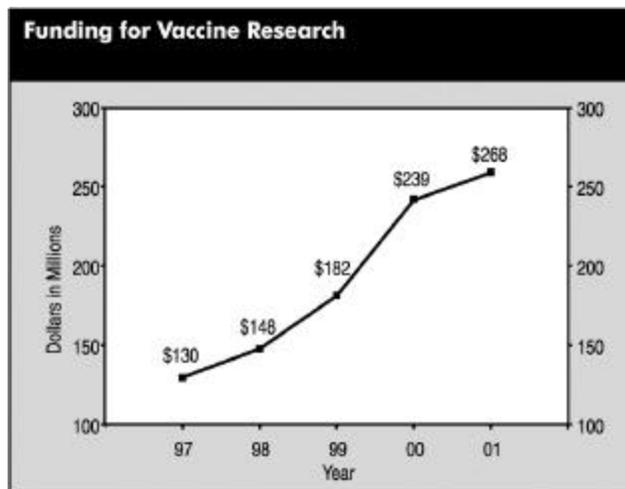
- **NIH-Wide Evaluation of AIDS Research**

OAR initiated a major evaluation of the entire trans-NIH program in 1996 to assure that the most promising areas of science were being supported, that critical scientific questions were being addressed, and that the most effective use was being made of federal AIDS research resources. The review was of unprecedented scope and breadth across all the NIH institutes and centers. The “Levine Report”, as it was known, provided a blueprint for restructuring the NIH AIDS science program to streamline research, strengthen high-quality programs, eliminate inadequate programs, and ensure that the American people reap the full benefits of their substantial investment in AIDS research.

- **Prevention Research**

AIDS Vaccine Initiative. A safe and effective HIV vaccine is essential for the global control of the AIDS pandemic. NIH has the largest single AIDS vaccine research program in the world. On May 18, 1997, President Clinton challenged the nation to develop an AIDS vaccine within 10 years. The President also announced a number of important initiatives to help fulfill this commitment, including high-level international collaboration, a dedicated research center for AIDS vaccine research at NIH, and outreach to scientists, pharmaceutical companies, and patient advocates to maximize the involvement of both the private and public sectors in the development of an AIDS vaccine. As of May 2000, NIAID (National Institute of Allergy and Infectious Disease)-supported researchers had evaluated 28 vaccine candidates and 12 adjuvants (substances incorporated into a vaccine that boost specific immune responses to vaccine) in more than 3,400 volunteers in Phase I/II clinical trials. On June 3, 1998, the FDA granted permission to VaxGen Inc. for the nation’s first Phase III clinical trial for an AIDS prevention vaccine. The trial of the vaccine, called AIDSVAX, will include at least 5,000 volunteers from the U.S., Canada, and Europe, and will last up to five years. A separate Phase III trial of AIDSVAX in Thailand will enroll 2,500 volunteers. In February 1999, NIH-supported investigators initiated the first AIDS vaccine trial in Africa.

CDC will play an important role in the AIDSVAX trials in the U.S., and continue to provide technical support to the Thailand trials. CDC’s role in HIV vaccine research is to work to determine the behavioral approaches necessary to maintain prevention progress during vaccine trials and ultimately during implementation of a vaccine program, if an effective and safe HIV vaccine is identified.



Consistent with the President’s challenge, NIH funding for HIV vaccine research increased by more than 100% between FY 1997 and FY 2000, resulting in the award of new grants to foster innovative research on HIV vaccines, including vaccine design and development, and the invigoration and reorganization of the NIH vaccine clinical trials effort. Construction of the new intramural Vaccine Research Center is complete, and world-renowned scientists have been recruited. The AIDS Vaccine Research Committee, chaired by Nobel Laureate Dr. David Baltimore, continues to provide critical advice on all aspects of the NIH AIDS vaccine development program. To establish a global infrastructure for HIV vaccine trials, NIAID has established a new comprehensive, clinically based research and development network, the HIV Vaccine Trials Network (HVTN), with an expanded, integrated clinical research agenda that has both domestic and international components.

Topical Microbicides Research. The vulnerability of women to be infected by HIV demands the development of effective and acceptable female-controlled chemical and physical barrier methods, such as topical microbicides, to reduce HIV transmission. To enhance and stimulate research in this area, OAR co-sponsored the first international conference devoted to all aspects of microbicide research and development, including more than 600 participants from 45 nations. NIH is supporting Phase I, II, and III trials of various topical microbicides. NIH also supports behavioral and social research on the acceptability and use of microbicides among different populations. NIH has recently completed a strategic plan for microbicide research.

Mother-to-Child Transmission. In the U.S., regimens of antiretroviral drugs resulting from NIH-supported research have dramatically reduced HIV transmission from infected mother to infant. NIH researchers first demonstrated the benefits of zidovudine (AZT) therapy for preventing mother-to-child transmission of HIV in 1994.

In 1998, researchers from CDC and the Ministry of Public Health in Thailand found that a short course of AZT given late in pregnancy and during delivery reduced the rate of HIV transmission to infants of infected mothers by half in non breast-feeding settings and is safe for use in the developing world. Studies in west Africa found that using this or a similar short course AZT

regimen resulted in about a one-third reduction in the risk of perinatal transmission among breast-feeding women. Another important study in Africa using a AZT/3TC combination found a similar reduction in risk.

Most recently, in the summer of 1999, results from a NIH-supported clinical trial in Uganda showed that use of a single dose of another antiretroviral drug, Nevirapine, given to the mother at the onset of labor and another dose given to her baby reduced the risk of transmission by about 50% when compared to a very short course of AZT given only at labor and for one week to the infant.

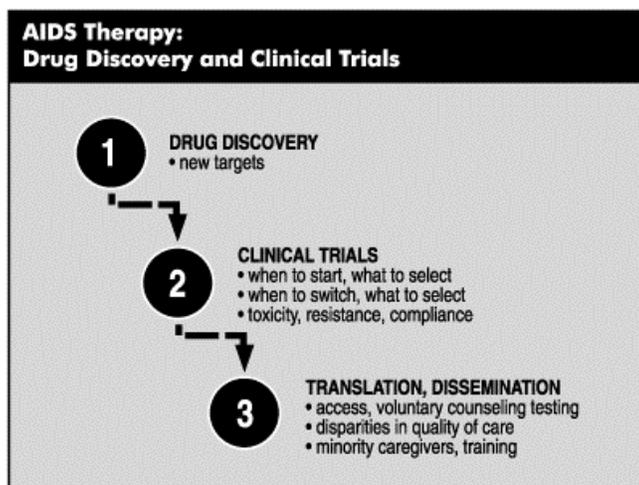
The United Nations International Children's Emergency Fund (UNICEF), the World Health Organization (WHO), and the United Nations Program on AIDS (UNAIDS), with technical assistance from CDC, are now working with public health agencies around the globe to help make these short-course regimens available for as many women as possible and to continue to identify practical solutions for reducing the toll of the HIV epidemic on women and children worldwide.

- **Behavioral and Social Science Research**

Both CDC and NIH conduct prevention research to assure that prevention efforts are based on sound behavioral and biomedical science. Studies have demonstrated that behavioral change can successfully prevent or reduce the spread of HIV infection in both domestic and international settings. Prevention programs resulting from such studies have reduced the risk of transmission in many communities and subgroups. NIH supports research to further understanding of how to change the behaviors that lead to HIV transmission, including preventing their initiation, and how to maintain protective behaviors once they are adopted in all populations at risk.

CDC's research focuses on identifying the factors that influence risky behavior and transmission in different communities, and evaluating various approaches to reducing risk. For example, CDC researchers have recently examined the important role parental communication can play in reducing risk behavior among young African-American and Latino youth. Research also has focused on developing and evaluating new approaches to counseling and testing for women at high risk. Other behavioral research initiatives include examining the effectiveness of peer interventions for gay men, street outreach for injection drug users, community-level interventions for young Latino men who have sex with men, HIV education for youth, and faith-based programs for African-American communities.

In June, 1998, the National Institute of Mental Health at NIH announced that its Multisite HIV Prevention Trial found that even among persons considered hardest to reach, educational sessions that motivate and offer specific strategies to reduce high-risk sexual behaviors can cut those behaviors in half. The National Institute on Drug Abuse at NIH has also conducted research on understanding the trends in HIV transmission among drug users and their sexual partners, as well as ways to reduce viral spread. As a result, innovative models of outreach have been developed to help stem the spread of HIV among this at-risk population.



- **Treatment Research**

Advances in understanding HIV and how it causes AIDS have helped scientists to develop an effective arsenal of drugs that, when used in combination, can help many people with HIV disease live longer and healthier lives. These achievements highlight the pivotal contributions of both NIH-supported basic research and NIH collaborations with academia and industry to develop effective anti-HIV therapies. For example, NIH-supported research was pivotal to discovering and defining the importance of the HIV protease enzyme. NIH-supported scientists helped determine the precise three-dimensional structure of HIV protease, a crucial step in designing drugs that block the action of the enzyme. NIH also supported researchers who helped drug-screening efforts by developing simple rapid tests to measure the inhibition of protease activity. These accomplishments set the stage for NIH collaboration with the pharmaceutical industry in developing the new class of anti-HIV drugs known as protease inhibitors. NIH worked closely with industry as they designed, produced, and clinically tested protease inhibitors. This collaboration helped speed product development.

NIH-supported investigators conclusively demonstrated that triple-drug combination therapy with a protease inhibitor and two other anti-HIV drugs was more effective than one- or two- drug regimens for long-term suppression of HIV. Basic researchers at NIH laboratories have helped explain why HIV can rebound in patients who discontinue combination therapy, and continue to open new avenues for drug development.

NIH clinical trials continue to study new anti-retroviral drugs and combinations of therapies to prevent disease progression and HIV-associated opportunistic infections and malignancies. NIH has also implemented guidelines requiring the inclusion of women and minorities in clinical trials.

- **Basic Research**

Of paramount importance is maintaining a strong commitment to basic research. Tremendous progress has been made through groundbreaking research on basic HIV biology and AIDS pathogenesis, revolutionizing the design of drugs, the methodologies for diagnosis, and the monitoring for efficacy of antiviral therapies. Recently, NIH researchers identified a new

genetic risk factor for HIV infection. A recently published study shows that a tiny variation in an immune system gene called RANTES can be a double-edged sword, substantially increasing one's susceptibility to HIV infection, but subsequently slowing down the disease's progress.

- **Women and AIDS**

NIH supports a number of epidemiologic cohort studies specifically focused on women and adolescents. These studies are designed to elucidate the pathogenic mechanisms more commonly observed in women, children and adolescents with HIV infection, and represent an important scientific link between epidemiology and basic research. Women also experience certain clinical manifestations of HIV infection that are unique and more prevalent than in men. The Women's Interagency HIV Study, a major study conducted in collaboration with other agencies, is identifying the nature and rate of HIV disease progression in women, characterizing clinical manifestations of HIV important to women, assessing the effects of therapeutic regimens, and identifying sociocultural and health care access factors that affect disease outcomes in women.

E. ELIMINATING RACIAL AND ETHNIC DISPARITIES

Although racial and ethnic minority groups account for only about 25% of the U.S. population, they account for more than 50% of all AIDS cases. While overall AIDS deaths are down, AIDS remained the leading killer of African-Americans ages 25-44 in 1998. In October 1998, President Clinton declared HIV/AIDS to be a severe and ongoing health crisis in racial and ethnic minority communities, and announced a comprehensive new initiative in collaboration with the Congressional Black Caucus to improve the nation's effectiveness in preventing and treating HIV/AIDS in African-American, Hispanic, and other minority communities.

In FY 1999, \$165.7 million in new targeted funding was provided for the Minority AIDS Initiative, increasing to an estimated \$350 million in FY 2001. The HHS Crisis Response Team initiative has also provided intensive technical assistance to large metropolitan areas with high numbers of HIV/AIDS cases among racial and ethnic minority populations.

In October 2000, CDC awarded \$19 million to community coalitions in 15 states to help address racial and ethnic disparities in health in the U.S. In addition, NIH contributed \$5 million, for a total of \$24 million, and has pledged to sustain that level of support for four additional years. This is the second year that CDC has awarded the funds as part of its "Racial and Ethnic Approaches to Community Health (REACH 2010)" initiative, a demonstration project that targets HIV/AIDS and five other health priority areas.

In addition to appropriated funds directly targeted to HIV prevention, care and treatment, and substance abuse and mental health prevention and treatment in minority communities, the FY 1999 and FY 2000 Public Health and Social Services Emergency Fund provided \$50 million to address high-priority HIV prevention and treatment needs of minority communities heavily impacted by HIV/AIDS. These resources were directed across three broad categories: technical assistance and infrastructure support; increasing access to prevention and care; and building stronger linkages to address the needs of specific populations. The Office of Minority Health and the Office of HIV/AIDS Policy have taken an active role in increasing the availability and

effectiveness of technical assistance and capacity development initiatives to strengthen the community-based response to HIV/AIDS in minority communities. The Office of HIV/AIDS Policy has also conducted the Surgeon General's Leadership Campaign on AIDS to raise awareness and involvement of minority leaders and decrease the stigma associated with HIV/AIDS.

- **Research**

Research to address the disproportionate impact of the HIV/AIDS epidemic on U.S. racial and ethnic minority communities continues to be a high priority at NIH. OAR has established the Ad Hoc Working Group on Minority Research to advise NIH on the scientific priorities, and NIH is directing increased resources towards new interventions that will have the greatest impact on these groups. NIH is also making significant investments to improve research infrastructure and training opportunities for minorities. NIH has provided additional funds to projects aimed at increasing the number of minority investigators conducting behavioral and clinical research; increasing outreach education programs targeting minority physicians and at-risk populations; targeting the links between substance abuse, sexual behaviors and HIV infection; and expanding the portfolio of population-based research. The Training and Career Development Workshops for racial and ethnic minority investigators provide minority investigators with an opportunity to learn about available NIH funding mechanisms and to meet and network with senior minority investigators who receive significant levels of NIH funding.

NIH has also implemented a series of guidelines, policies, and programs to ensure that HIV-infected individuals from the most at-risk populations for HIV/AIDS are enrolled and accrued into federally sponsored AIDS studies. In 1994, the NIH implemented revised Guidelines on the Inclusion of Women and Minorities in Clinical Research, requiring applicants to address the appropriate inclusion of women and minorities in clinical research. Applications that fail to meet these requirements, as evaluated by peer review, are barred from funding.

- **Care and Treatment**

The Ryan White CARE Act is reaching minorities living with HIV disease – more than 60% of clients served are minorities. The proportion of minority CARE Act clients mirrors the proportion of total AIDS cases that are among minorities. Minority women and children are the most heavily impacted groups: three out of five women newly diagnosed with HIV/AIDS are African-American, and one out of five is Hispanic; and over 80% of AIDS cases among children are among racial and ethnic minorities. As part of the Minority AIDS Initiative, over 100 new planning grants have been awarded to help community-based organizations develop primary health care services for HIV/AIDS in minority communities. The Targeted Provider Education Program has also directed new outreach efforts to minority providers of health and social services to increase their knowledge about HIV/AIDS.

- **Substance Abuse and Mental Health Services**

SAMHSA has made both new and enhanced investments in substance abuse treatment services as part of the Minority AIDS Initiative, totaling \$73.6 million over FY 1999 and FY 2000. These include \$32 million for Targeted Capacity Expansion Programs for Substance Abuse Treatment and HIV/AIDS Services, \$13.5 million for Targeted Capacity Expansion for

Substance Abuse Prevention and HIV Prevention, \$9.5 million for the Community-Based Substance Abuse and HIV/AIDS Outreach Program, other resources for integrated services planning grants, and developmental technical assistance for minority community-based organizations. SAMHSA has placed special emphasis on addressing the needs of minority women around substance abuse treatment and prevention issues. In 1999, SAMHSA sponsored two policy fora focusing on coordination of HIV/AIDS, substance abuse and mental health services for African American and Latina women. An interagency working group has also been established to address potential gaps in care and services for women infected and affected by HIV/AIDS.

- **Prevention**

The most effective prevention programs are targeted to specific needs of communities at risk for HIV transmission. CDC funding enables local community organizations to mount targeted prevention programs that are based on sound science. CDC's efforts to ensure that prevention programs are effectively directed toward those in greatest need have resulted in a substantial increase in HIV prevention funding targeted to African-Americans and Latinos. The implementation of community planning has dramatically increased funds targeted to African-American and Latino communities, resulting in an increase from approximately \$17 million in 1993 to more than \$67 million in 1999.

Recognizing the critical role of the faith community in mobilizing community leaders and reaching and serving those at risk, CDC established a collaboration with the faith community in 1987. By partnering with a small group of national faith organizations and schools of public health, CDC leverages relatively modest resources into remarkable programs for HIV prevention with communities of faith nationally.

Key Administration Events, 1993-2000

March 1993	The Department of Health and Human Services launches the National HIV Telephone Consulting Service for health care professionals treating people with HIV and AIDS.
June 1993	President Clinton creates the Office of National AIDS Policy. President Clinton signs legislation creating a permanent office of AIDS Research at the National Institutes of Health. The Clinton-Gore Administration fights for full funding of the Ryan White CARE Act.
August 1993	President Clinton issues executive memorandum to heads of departments and agencies instructing them to implement ongoing HIV/AIDS education and prevention programs and to develop nondiscriminatory workplace policies for employees with HIV/AIDS.
November 1993	President Clinton establishes the National Task Force on AIDS Drug Development to create a public-private sector partnership to speed AIDS drugs to market.
January 1994	President Clinton launches the National AIDS Awareness Advertising Campaign.
September 1994	The Department of Health and Human Services hosts a National Congress on HIV/AIDS in Racial and Ethnic Communities.
December 1994	The Department of Health and Human Services launches the Prevention Marketing Initiative, designed to prevent the sexual transmission of HIV among young people.
December 1995	President Clinton hosts the first White House Conference on HIV and AIDS. President Clinton directs all departments and agencies to develop a coordinated plan for Federal HIV and AIDS research. The Food and Drug Administration approves the first protease inhibitor drug for treatment of HIV.
December 1996	The White House releases the First National AIDS Strategy Report.
March 1996	The Food and Drug Administration approves the first test for HIV antigen blood screening.
May 1996	President Clinton signs the reauthorization of the Ryan White CARE Act, providing critical treatment to thousands of people with HIV and AIDS.
June 1996	President Clinton creates the President's Advisory Council on HIV and AIDS.
July 1996	Secretary Shalala speaks to the 11 th International Conference on AIDS and announces that the U.S. will increase its commitment to HIV prevention research.
March 1997	The Food and Drug Administration approves the first protease inhibitor with labeling for use in children. The Clinton-Gore Administration releases the first federal biomedical research plan for HIV and AIDS.
May 1997	President Clinton launches the Comprehensive AIDS Vaccine Research Initiative, with the goal of developing an AIDS vaccine within 10 years.

June 1997	The Department of Health and Human Services releases the first-ever treatment guidelines for HIV and AIDS.
August 1997	The President releases new regulations requiring pharmaceutical manufacturers of new and current drugs to do both testing and labeling for medications that are widely used by pediatric populations.
November 1997	The President enacts the FDA Modernization Act, including important measures to accelerate review of important new medications.
June 1998	The Food and Drug Administration approves the first large-scale trial of an AIDS prevention vaccine.
October 1998	President Clinton launches a new national effort to address HIV and AIDS in racial and ethnic minority communities. The Substance Abuse and Mental Health Administration launches a new grant program targeting individuals with substance abuse problems in racial and ethnic communities with high AIDS rates.
February 1999	The National Institutes of Health launches the first AIDS vaccine trial in Africa.
June 1999	The Clinton-Gore Administration sends crisis response teams to 11 U.S. metropolitan areas to combat the spread of HIV/AIDS among racial and ethnic minority populations.
December 1999	President Clinton signs the Work Incentives Improvement Act, which provides \$250 million for a Medicaid buy-in demonstration to provide health insurance to people whose disability is not yet so severe that they cannot work, including those with HIV and AIDS. The Centers for Disease Control issues guidelines to help states implement effective HIV surveillance systems.
February 2000	The Department of Health and Human Services approves the Maine Medicaid demonstration plan, providing early intervention and treatment services for individuals with HIV.
May 2000	President Clinton launches the Millennium Vaccine Initiative, a new effort to expand and accelerate vaccine research and promote the purchase and delivery of existing vaccines. The Centers for Disease Control begins work on the “Know Now!” campaign to promote AIDS prevention.
August 2000	The Department of Health and Human Services notified the first eligible families approved to receive payments from the Ricky Ray Hemophilia Relief Fund. The Clinton-Gore Administration worked throughout the past year to achieve a \$75 million appropriation for FY 2000, and continues to fight for full funding.
October 2000	President Clinton signs the reauthorization of the Ryan White CARE Act, which serves 500,000 people with HIV and AIDS.
December 2000	The White House hosts a Religious Leaders’ Summit on the occasion of World AIDS Day 2000. President Clinton delivers an AIDS address at Howard University. The Clinton Administration works with Congress to advocate a strategy for new, unprecedented investment in HIV/AIDS research, prevention, and treatment pending in the Labor-HHS appropriations bill.

III. National Challenges

“We have many challenges ahead of us including overcoming complacency, combating stigma and homophobia, and ensuring that everyone has the knowledge, resources, and power needed to have a fighting chance against HIV. It is only through eliminating these forms of oppression that we can ensure that every American, regardless of who they are or where they live, can look forward to a future free from AIDS.”

Paul Kawata
Executive Director, National Minority AIDS Council

There is no question that the Clinton-Gore Administration’s response to the HIV/AIDS epidemic has slowed the rapid growth of the epidemic, but much more work remains to be done. The last 15 years have witnessed a shift in the epidemic, with a dramatic decline of new AIDS cases among gay men, but at the same time, the number of new AIDS cases among women, minorities, and adolescents has increased considerably. The continuing challenges facing our public health programs and our society include:

- Increasing the awareness among those with HIV of their HIV serostatus, and entering these individuals into appropriate care. To achieve this means eliminating the stigma and discrimination associated with HIV – which act as powerful deterrents to seeking testing, acknowledging HIV status to family and community, and entering health care.
- Providing lifesaving antiretroviral drugs and supportive services to maintain safe behaviors and reduce the terrible impact of the epidemic. This will require us to continue to explore avenues for expanding access to lifesaving therapies for individuals living with HIV/AIDS.
- Redoubling prevention efforts, with enhanced and targeted prevention to reach out to populations highly affected by HIV, including women of color, gay men of color, individuals caught in substance abuse, and youth under age 25 who now represent half of all new HIV infections.
- Continuing our investment in basic biomedical and behavioral research, to discover better and easier treatment regimens and define effective prevention strategies and programs responsive to the demographics of the epidemic.

IV. The Global AIDS Pandemic

“The problems caused by HIV/AIDS throughout the world need and deserve the attention of America. We cannot bear witness to a situation that will kill more people than all world wars combined and will cause severe devastation to the human family. We have a responsibility to prevent this holocaust.”

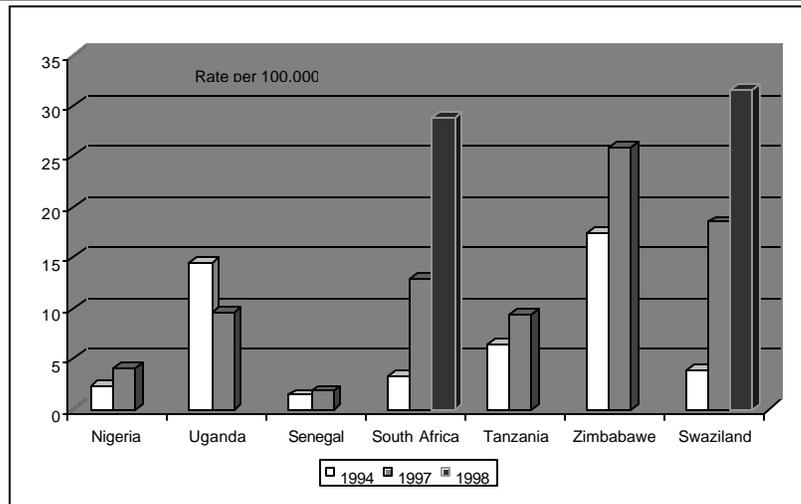
Ron Dellums
Chair, Presidential Advisory Council on HIV/AIDS

The HIV/AIDS pandemic is the defining public health crisis of our time. Not only is the spread of HIV creating a humanitarian tragedy of epic proportion, it is also threatening to undo four decades of progress in international development, and endangering the economic and political stability of entire regions of the world. At the start of the 1990's, health experts estimated that between 15 and 20 million people would be living with HIV by the beginning of the 21st century. Ten years later, the true magnitude of the epidemic is far more alarming: over 36 million people are living with HIV.

Since its first recognition in 1981, 57 million men, women and children have become infected with HIV worldwide. Nearly 22 million people have died of AIDS, with 3 million deaths in the last year alone. Over 13 million children under 15 have lost one or both parents to AIDS, and the total number of AIDS orphans is expected to exceed 40 million by 2010. HIV/AIDS is now the 4th leading cause of death worldwide and the single leading cause of death in sub-Saharan Africa.

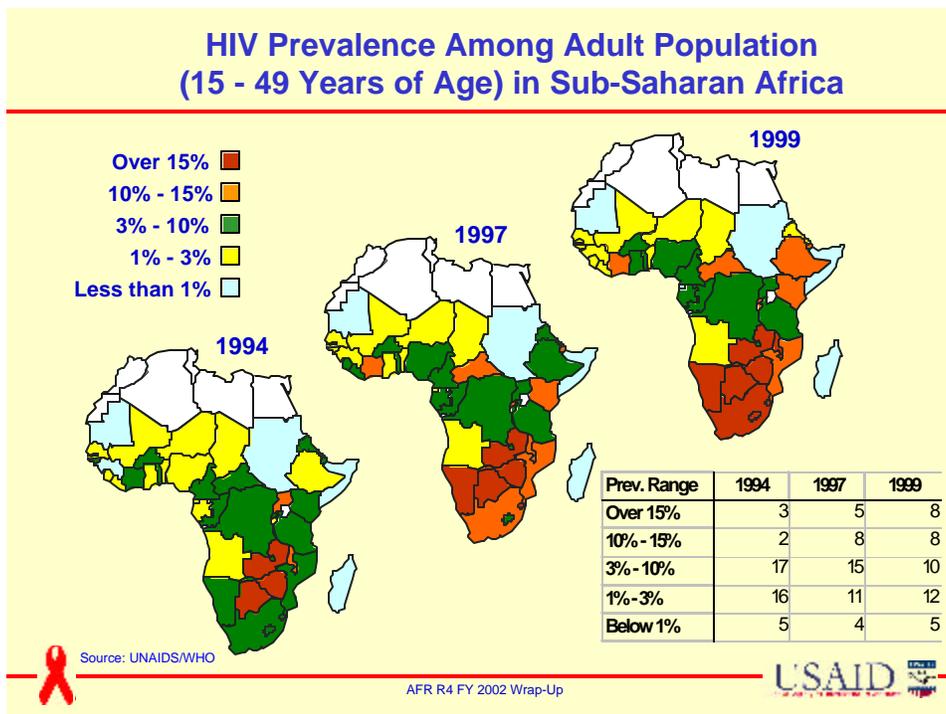
No part of the globe is untouched. Every country of the world has reported cases of HIV/AIDS. At the dawn of this century, HIV/AIDS prevalence among adults exceeded 20% in 7 countries in the developing world (all in Africa), and was above 10% in 9 additional countries. In another 41 countries, prevalence equals or exceeds 1%. 22 of these are in Africa, 11 are in Latin America, 4 in Asia, and 1 in Eurasia. In contrast, HIV/AIDS prevalence in the United States was 0.6% at the end of 1999.

HIV Prevalence Trends in Selected African Countries



Source: UNAIDS

HIV Prevalence Among Adult Population (15 - 49 Years of Age) in Sub-Saharan Africa



Sub-Saharan Africa, where 70% of all persons living with HIV/AIDS reside, has borne the brunt of the pandemic. In the hardest-hit African countries, infant mortality is twice as high as it would have been without AIDS. With increases in premature death due to AIDS, life expectancy has plummeted. Nearly half of all persons who acquire HIV are less than 25 years of age; most

will die before their 35th birthday. AIDS mortality has brought population growth to a near standstill in Botswana, South African, and Zimbabwe. Within three years' time, these countries will be experiencing declines in the size of their populations due to AIDS deaths.

The economic toll on Africa is equally striking. Families caring for sick members are seeing a dramatic drop in income and productivity. As a result, children are being removed from school, farm assets are being sold, and communities are seeing food production decline by as much as 50%. In the hardest-hit countries, GDP has declined by 5% to 10% as all economic sectors are being affected. For example, trucking firms in South Africa have lost up to 30% of their drivers, reducing their ability to move goods to market. Schoolteachers in Zambia are dying faster than new ones can be trained. The health sector is bearing a double burden from HIV/AIDS. Health systems are shouldering the demands of providing care to millions of people sick and dying from AIDS, while the health care workforce is declining due to AIDS deaths among doctors, nurses, and midwives.

Other parts of the world have not been spared the ravages of the pandemic. The second largest regional epidemic is in the Asia Pacific region, where nearly 60% of the world's population lives. With its dense populations, this part of the world could eclipse the African epidemics in size and scope. We have seen the epidemic explode in Cambodia, Burma, Thailand, and some states of India. Even with a prevalence of less than 1%, India is the second most affected country in the world, with over 3 million people infected. Other countries in the region, most notably Indonesia and Philippines, have maintained low prevalence epidemics over the last decade, giving rise to hope that with successful behavioral interventions, this region's epidemics can be contained.

Other epidemics are spreading rapidly as well. In the Western Hemisphere, the epidemics in the Caribbean region are the fastest growing outside of Africa, fueled largely by heterosexual contact. Over the last five years, Eastern Europe and the former Soviet states have seen an explosive epidemic of HIV among injection drug users. These epidemics are now showing signs of entering the general population.

The global HIV/AIDS pandemic poses a dual challenge to the nations of the world. The first challenge is to address the urgent need to implement and scale up prevention programs known to slow the spread of HIV. The second is to address the health care needs of the millions of persons infected, and to provide assistance to the families and communities ravaged by this extraordinary emergency.

V. Leading the Fight Against HIV/AIDS Worldwide

“The Clinton Administration has sounded the alarm on the global AIDS crisis – and has pulled out all of the stops in mobilizing the global community around this fight. By declaring the global pandemic a security threat and getting the United Nations to do the same, President Clinton has elevated this issue to the very top of the international agenda.”

Peter Lamptey
Vice President, Family Health International

The U.S. government has been the world leader in responding to the global pandemic of AIDS. Since 1993, the U.S., through the United States Agency for International Development (USAID), has dedicated over \$1.5 billion for the prevention and mitigation of this epidemic in the developing world. In addition to this financial support, USAID has been recognized as the global leader in developing key interventions for preventing HIV transmission, demonstrating their effectiveness, and providing direct assistance to affected countries to build their capacity to respond.

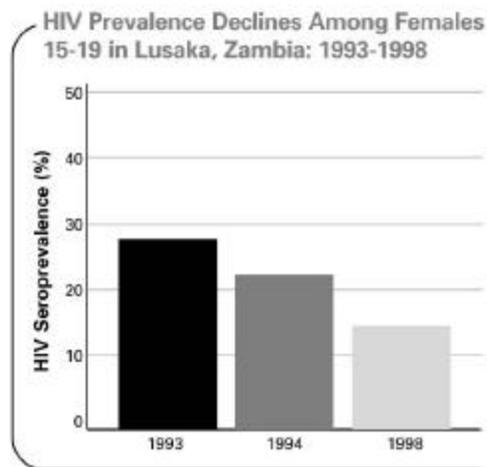
USAID works in more than 50 of the hardest hit developing countries around the world. Preventing sexual transmission, which is responsible for about 80% of HIV infections, is central to our widespread efforts in service delivery, capacity building, biomedical and behavioral research, and policy formulation. Over the past decade, we have worked with local governments and community groups to provide intensive AIDS education to over 40 million of the most vulnerable men, women, and young persons, helping them to reduce their risk of HIV infection. To accomplish this task, USAID has trained over 200,000 new dedicated counselors and educators. In 1998, with the release of clinical field trial data on new ways to reduce mother-to-infant HIV transmission, which accounts for over 10% of new infections, USAID launched a series of country sites to provide this important new prevention service. But while prevention is the guiding principle of our programs, we have learned that we cannot have a truly effective prevention program without providing basic care and support services to those infected and to their families. We now provide assistance to increase access to HIV testing, improving symptomatic care and treatment of opportunistic infections such as tuberculosis, and initiating field trials to explore ways to deliver simpler and less expensive antiviral treatment regimens.

The following are some of the ways the U.S. government and USAID have been successful in the global fight against HIV/AIDS:

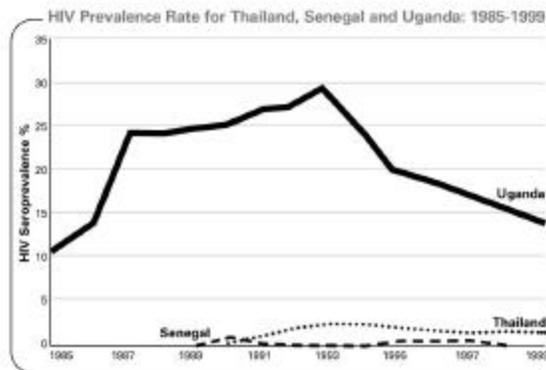
- **Provided direct support to countries to help prevent new infections and to care for those infected and their families.** Over 70% of USAID's support in HIV/AIDS has been through the work of nearly 1,000 local and international non-governmental organizations (NGOs) and community-based organizations (CBOs). NGOs are often relied on to reach those most vulnerable to infection and in need of care and support services. USAID places a high priority on building the capacity of local NGOs through partnerships with other developing country NGOs, international technical assistance providers, and U.S.-based AIDS service organizations. Recognizing the need to keep pace with the pandemic, USAID is

increasing the coverage of its programs through local institutions to reach those most in need of services.

- **Helped reduce HIV prevalence in young adults in Uganda and Zambia.** USAID's support was instrumental in reducing the prevalence of HIV in 15-24 year olds in urban areas of Uganda by 50%, and nationally by one-third. Similarly, with the help of USAID, over the past few years Zambia has achieved a 42% reduction in the rate of HIV among 15-19 year-olds.



- **Helped maintain low HIV prevalence rate in Senegal, Philippines, and Indonesia, and stabilized HIV prevalence rates in Kenya.** Early, comprehensive HIV intervention programs supported by USAID and other donors in Senegal, Philippines and Indonesia have helped prevent a major epidemic, keeping the prevalence rate to less than 2%. USAID has also been instrumental in stabilizing the HIV prevalence rate in Kenya, and reducing national rates of sexually transmitted diseases (STDs).



- **Pioneered voluntary HIV testing and counseling in Africa.** In 1990, USAID provided funding for the AIDS Information Center in Uganda, the first program in Africa offering voluntary and anonymous HIV counseling and testing. In eight years, over 400,000 clients were served. Building on this success, USAID now supports voluntary counseling and testing in more than 15 countries.
- **Increased distribution of condoms.** USAID has provided over one billion condoms and developed new technologies so that people can protect themselves and their partners. In Thailand, through a 100% “condom only” brothel policy and intensive general and targeted interventions focused on behavioral change, HIV prevalence has been kept at 2% over the past four years, and sexually transmitted infection (STI) rates in men have dropped by 300%. USAID support for social marketing of condoms has increased sales by over 100% between 1996 and 1998 in Kenya, Madagascar, Mozambique, and Zimbabwe. In 1999, USAID launched new social marketing programs in Eritrea, South Africa, and Haiti.
- **Provided funding to the Census Bureau for tracking HIV trends.** Early in the epidemic, USAID recognized the importance of collecting essential surveillance data to track the expanding epidemic and to measure the impact of prevention efforts. In 1987, USAID initiated funding for the International Programs Center at the U.S. Bureau of Census to collect HIV surveillance data, analyze the significance of the data, provide technical assistance to country programs, and provide conclusions and recommendations. The Census Bureau is now recognized as the worldwide leader in tracking patterns and trends in HIV infection, such as projecting the numbers of AIDS orphans and providing critical data for the annual UNAIDS global report.
- **Launched International HIV/AIDS Alliance.** In 1993, USAID consulted with HIV/AIDS experts and NGO support specialists and joined a small group of bilateral, multilateral, and private donors to establish the International HIV/AIDS Alliance (IHAA), an innovative mechanism to directly address the urgent problem of building the capacity of country-level NGOs and community-based groups to provide effective responses to the epidemic. The IHAA model is to identify a qualified indigenous NGO in a target country, provide funding and training in both administrative and technical aspects of HIV/AIDS service delivery, and assist the NGO in helping smaller CBOs deliver culturally appropriate, technically sound services to households and villages, where the realities of the HIV/AIDS epidemic unfold. The International HIV/AIDS Alliance has experienced steady growth from an annual budget of \$3.5 million in 1997 to over \$5 million in 1999. Donor support to the Alliance has grown to include the European Union (EU) and its member states, the UN organizations and other multilaterals, and private foundations and companies. In 1999, the Alliance reached 1.5 million beneficiaries – nearly 400 NGOs in 13 countries – almost an 80% increase from 1998.
- **Supported the development of GIPA.** In 1994, USAID played a major role in supporting the Greater Involvement of Persons Living with AIDS (GIPA) Initiative at the Paris AIDS Summit. This initiative recognizes the critical contributions that persons infected with AIDS can provide to the design, implementation and evaluation of culturally sensitive and effective prevention and care efforts. USAID strives to ensure that the GIPA principle is reflected in all of its assistance projects.

- **Addressed the impact of HIV/AIDS among women.** USAID leadership has built new knowledge and capacity to address the overwhelmingly heterosexual epidemic in developing countries by providing over \$5 million to the International Center for Research on Women (ICRW). This program of 17 studies in 13 countries was the first concerted effort to document the impact of the epidemic in regions where over half of HIV infections are among women and girls, and where they are the principal providers of AIDS care. ICRW supported policy dialog and promoted innovative interventions to deal with the economic, social, and political disadvantages that increases women's vulnerability to HIV infection, and it moved issues of gender squarely to center stage in international HIV/AIDS work.
- **Helped to create and fund UNAIDS.** Concerned with the need for a broader, more effective response to the AIDS pandemic, the U.S. government worked with other donor and UN partners to create the Joint United Nations Program on AIDS (UNAIDS), which was launched in 1996. UNAIDS is an innovative program which brings the UN family together in a “joint venture” to fight AIDS. The U.S. government, through USAID, has been UNAIDS’ largest funder, having given over \$80 million in grant assistance since the program’s inception.

UNAIDS documented and publicized the full dimensions of the global AIDS crisis, and helped focus world leaders’ attention on the crisis and how to respond to it at global fora such as the UN Millennium Summit, UN Security Council meetings, and the Africa Development Forum. In June 2001, a special session of the UN General Assembly will be devoted to HIV/AIDS. UNAIDS “Theme Groups on HIV/AIDS” were established in 86 out of 88 priority countries, and technical teams in priority areas such as access to drugs, education, mother-to-child transmission, and voluntary counseling and testing are functioning.

In large part due to the leadership of UNAIDS, global HIV/AIDS reduction targets have been set, and global, UN, and national strategies have been developed to achieve them. The International Partnership Against AIDS in Africa was formed, which has begun to mobilize political commitment. More national leaders have assumed responsibility for combating AIDS. International commitments from pharmaceutical companies and the business sector, private foundations, the UN, the World Bank, and the bilateral donor community increased an estimated 2.5 times from 1997 to 2000. In one example, UNICEF in East and South Africa has committed to spending 50% of its resources on AIDS. Additional funding sources are being tapped, such as the innovative use of debt relief, and the stage is set for further increases in resources for HIV/AIDS in 2001.

- **Leading the way in research and development.** USAID has been a leader in innovative research and development to prevent and mitigate the effects of the AIDS pandemic. Without USAID support, many innovative products and methods would have never been developed. The results of this research have proven useful in the U.S. as well as in developing countries. USAID-funded research was pivotal in the following achievements:
 - Securing FDA approval of the Reddy **Female Condom**, making this woman-controlled barrier method available in the U.S. and around the world;

- Development of a **syphilis test** that is simple, inexpensive, and can be used in low-resource settings to diagnose and effectively treat this common STI whose presence increases the efficiency of HIV transmission;
- A 3-country study showing that providing high quality **HIV testing and counseling** services results in sustained behavior change and is a cost-effective HIV prevention intervention.
- Demonstrating that levels of **STIs** in whole communities could be reduced with periodic treatment of persons at highest risk.

USAID continues to support the development of innovative technologies and methods to reduce the spread of HIV and mitigate its effects. These include HIV vaccines, microbicides, diagnostic tests for sexually transmitted infections, improving the effectiveness of AIDS education in the classroom and the workplace, assisting mothers and families in preventing mother-to-child transmission of HIV, and expanding care and support for people and families infected with and affected by HIV.

- **Identifying the tragic aftermath of HIV on children.** HIV/AIDS is undermining the safety and well-being of children in unprecedented ways and on a staggering scale. Leading the call to action to recognize the severity of the situation of children affected by HIV/AIDS, USAID released a seminal report on World AIDS Day 1997. *“Children on the Brink: Strategies to Support Children Isolated by HIV/AIDS”* helped to define the nature and magnitude of the problem and identified strategies to address it that have guided the development of activities worldwide. Updated in July 2000, the report is the source of estimates and projections of children who will have lost one or both parents from all causes, including AIDS, in a sample of 34 severely affected countries.

USAID began its direct support of programs to address the needs of children affected by HIV/AIDS in 1998, and is currently funding activities that focus on orphans and other vulnerable children in 18 countries. The foundation of the USAID response is to strengthen family and community capacity to continue to care for these children within their communities. Funding provides necessary support to ongoing community efforts and fosters the creation of similar efforts where they do not yet exist. Community-based interventions include volunteer visiting programs; material support, such as food and shelter; economic strengthening activities, including credit and savings; counseling and ongoing emotional support; support to parents in planning for the future care of their children; and interventions by which communities address the stigma that is often directed at people living with HIV/AIDS and their families. Training activities build local capacity of organizations that provide care and support to communities and families coping with HIV/AIDS. Operations research has been initiated to determine optimal community-based approaches that provide support to children and their families. Planning efforts identify and develop strategies to address the impacts of HIV/AIDS on the accessibility and quality of education – both in and out of school – in AIDS-affected areas.

VI. Expanding Our Efforts

“Today, Africa stands on the brink of a new day. But as we work toward a better and brighter future for our children and our grandchildren, the raging horror of AIDS threatens to leave an entire generation in jeopardy. Every day, lives are being lost, families are being torn apart, and the dreams of our young people are being shattered.”

Archbishop Desmond Tutu

From years of painful experience with this pandemic, it has become increasingly evident that a cornerstone for success in the battle against AIDS is clear and consistent leadership. The challenges presented by this growing plague are great, and in the absence of a steadfast commitment from political leaders at all levels of government and from civic leaders from all sectors of society, our ability to prevail is seriously jeopardized. We saw this kind of leadership in Uganda, Senegal, and Thailand in the early days of this pandemic – and we bore witness to the real results achieved through these bold and decisive actions that started with the heads of state. Despite seemingly insurmountable odds, we saw communities and entire countries stem the rising tide of new infections and begin to care for the growing number of people infected and affected by HIV. But as a global community, our collective action was being far outpaced by a pandemic raging out of control – and strengthened leadership was desperately needed.

In April 1998, President and Mrs. Clinton traveled to Africa and spent two weeks visiting five countries. During that time, they witnessed firsthand the grave implications of the AIDS pandemic at its epicenter: sub-Saharan Africa. This experience reconfirmed what this Administration had already begun to understand – that the global AIDS crisis was much more than a health crisis; it was a fundamental development crisis, an economic and trade crisis, and a stability and security crisis. Such a crisis clearly demanded a more broad-based response, not just from the U.S. government but from the global community. To that end, on December 1, 1998, President Clinton charged the director of the White House Office of National AIDS Policy with leading an AIDS fact-finding mission to sub-Saharan Africa and reporting back with a battle plan for an enhanced response.

The LIFE Initiative: An unprecedented U.S. government mobilization effort

In July 1999, the Clinton Administration launched an initiative called Leadership and Investment in Fighting an Epidemic, or LIFE. LIFE represented a major breakthrough – a turning point in the role of the U.S. government in the global battle against AIDS. This effort sought not only to increase U.S. investment but also to dramatically enhance U.S. leadership in a global mobilization toward our shared goals in the fight against AIDS. These goals, put forward by UNAIDS in cooperation with its bilateral or multilateral partners, are as follows:

- The incidence of HIV infection will be reduced by 25% among 15-24 year olds by 2005.

- At least 75% of HIV-infected persons will have access to basic care and support services at the home and community levels, including drugs for common opportunistic infections (tuberculosis, pneumonia, and diarrhea).
- Orphans will have access to education and food on an equal basis with their non-orphaned peers.
- By 2001, domestic and external resources available for HIV/AIDS efforts in Africa will have doubled to \$300 million per year.
- By 2005, 50% of HIV-infected pregnant women will have access to interventions to reduce mother-to-child HIV transmission.

The LIFE initiative has enabled the U.S. government to pursue four critically important and interconnected program areas:

1. **Containing the AIDS Pandemic.** Implementing a variety of prevention and stigma reduction strategies, especially for women and youth, including HIV education; engagement of political, religious, and other leaders; voluntary counseling and testing; interventions to reduce mother-to-child transmission; and enhance training and technical assistance efforts including Department of Defense efforts with African militaries.
2. **Providing Home- and Community-Based Care.** Delivering counseling, support, palliative and basic medical care, including treatment for STDs, opportunistic infections, and tuberculosis through community-based clinics and home-based care workers. Enhancing training and technical assistance efforts.
3. **Caring for Children Orphaned by AIDS.** Assisting families, extended families, and communities in caring for their children through nutritional assistance, education, training, health, and counseling support in coordination with micro-finance programs.
4. **Strengthening Prevention and Treatment by Augmenting Planning, Infrastructure, and Capacity Development.** Strengthening host countries' ability to plan and implement effective interventions. Strengthening the capacity for effective partnerships and the ability of CBOs to deliver essential services. Strengthening surveillance systems to track the epidemic and target HIV/AIDS programs.

The LIFE Initiative has enabled the U.S. government to more than *triple* its AIDS-specific investment in the global battle against AIDS over the last two fiscal years, and to further expand these increased resources through debt relief, concessional loans at the World Bank, and other important efforts.

Global AIDS Funding (in millions)

	FY 99	FY 01
AIDS-Specific Funding		
USAID	\$140	\$330
CDC/LIFE Initiative	\$ 0	*\$116
DOD	\$ 0	\$ 10
DOL	\$ 0	*\$ 10
TOTAL	\$140	*\$466
Non-AIDS-Specific Funding		
Debt Relief	\$0	\$435
GAVI	\$0	\$ 50
World Bank Concessional Loans targeted to AIDS	\$0	\$500

*Anticipated FY 2001 level

The LIFE initiative has enabled the U.S. government to engage a host of federal agencies in the first ever government-wide mobilization against AIDS:

- USAID.** From years of extensive experience in the 50 countries around the world in which USAID provides AIDS funding, the agency has developed and evaluated model programs that the agency can now begin to bring to scale. As a result of new funding provided through the LIFE initiative in FY 2000, USAID was able to provide a more intensive focus in 15 countries, including those hardest hit in sub-Saharan Africa and India. With the additional resources secured in FY 2001, USAID will be able to expand this intensive focus to 20 countries, providing additional resources and support to Russia, Cambodia, and the Mekong Delta Region, the Caribbean, and Brazil. In addition, in FY 2001, USAID will identify four countries that are positioned for rapid scale-up of essential activities. These countries will be selected from a variety of criteria, including the severity of the epidemic, its impact on economic and social sectors, strength of support from the host government, and ability to demonstrate quantifiable results. As additional agencies have become part of the overall U.S. government effort, USAID has remained the lead agency on the ground throughout the world, providing in-country presence and coordination.

The LIFE initiative has also enabled USAID to pioneer and push for a broad-based multisectoral approach. Recognizing the enormous impact of HIV/AIDS on multiple sectors, particularly in Africa, USAID has documented the impact of the epidemic as well as developed appropriate interventions. Efforts have focused on the education sector, certain economic sectors (such as mining), microfinance, democracy and governance, and agriculture. In the education sector in particular, USAID has worked very closely with other donors to identify solutions to the loss of teachers to HIV/AIDS, as well as to design curriculum addressing HIV/AIDS prevention. Moreover, USAID has been working to address the key underlying factors that encourage HIV/AIDS transmission, such as the lack of inheritance rights for women, economic migration patterns, and conflict that results in refugee movements.

- **Centers for Disease Control and Prevention (CDC).** In collaboration with USAID and the other agencies of the Department of Health and Human Services, the CDC is providing vital public health assistance to 14 countries in Africa and India to combat the HIV/AIDS epidemic. Ongoing activities are focused in three areas:
 1. Provision of technical assistance for primary HIV prevention (voluntary HIV counseling and testing, blood safety, behavioral change, and mother-to-child transmission);
 2. Assistance in developing surveillance programs to target prevention resources and assess the effects of HIV prevention interventions; and
 3. Provision of technical assistance for the care and treatment of opportunistic infections and STDs, and for the provision of palliative care and psychosocial support to persons living with HIV/AIDS and their families.

HHS and CDC expect to expand these efforts with increased resources in FY 2001. Enhanced activities would include increased technical assistance and support to improve national surveillance programs for HIV, STDs, and tuberculosis; infrastructure support through expanded in-country and U.S.-based training efforts for host country epidemiologists, HIV prevention and care program managers, and service delivery providers; expansion of home-based-care service delivery capacity, and assistance in developing locally appropriate care and treatment interventions for HIV-infected persons; and expanded HIV prevention initiatives in mother-to-child transmission.

- **Department of Defense.** Under the LIFE initiative, the Department of Defense allocated \$10 million in FY 2001 to assist African militaries in designing and executing HIV/AIDS education and prevention programs for military troops, and to integrate the “train the trainer” programs into U.S. forces engaged with African militaries. Specifically, the Defense program will seek to assess HIV prevalence and risk behaviors, develop and augment regional and local prevention plans through training and infrastructure, evaluate the effect of prevention efforts, and ensure incorporation of HIV/AIDS programs into the military culture of host governments to ensure a lasting impact. The program is intended to continue beyond FY 2002 as long as funds are available. The U.S. Navy and its Naval Health Research Center are the primary implementing agencies for this program.

The U.S. Army and the Civil Military Alliance to Combat HIV and AIDS have also developed prevention and education modules for training UN peacekeepers prior to deployment, and continue to work with the UN Department for Peacekeeping Operations on activities related to HIV/AIDS and STD prevention. Through an expanded International Military Education and Training (IMET) program, the International Health Resources Management School in Monterey, California, is developing executive-level training courses for senior civilian and military leaders responsible for HIV/AIDS in other countries. These courses will be taught as part of the E-IMET program starting in early 2001.

- **Department of Labor.** Utilizing reprogrammed FY 2000 funding, the Department of Labor has begun a pilot project on workplace-based HIV/AIDS education in the Republic of Malawi in south central Africa. Working with the Ministry of Labor, employers, trade unions, a vocational school, and U.S.-based Project Hope, the project seeks to implement and evaluate a comprehensive workplace-based HIV prevention program. The Department plans to expand this program in FY 2001 with the \$10 million currently pending in Congress. This

expansion will draw on lessons learned from the Malawi project and will include Nigeria, Tanzania, Zambia, and Botswana in sub-Saharan Africa; India, Vietnam, and Cambodia in Asia; a regional program in the Caribbean; and Russia. The overall objective of this effort is to reduce HIV infections through workplace prevention programs and to improve the workplace environment for people living with AIDS through the development of non-discrimination and other HIV/AIDS policies.

- **Department of State.** The Department of State has launched a diplomatic initiative on international HIV/AIDS to raise the profile of this issue around the world and to foster a deeper commitment overseas to this fight. The Secretary's initiative instructed U.S. ambassadors to work with foreign leaders and their governments on the need to increase the priority given to HIV/AIDS and resources available for essential HIV prevention and AIDS care programs. The Department also works closely with international organizations, other governments, and the private sector to draw greater attention to HIV/AIDS and the need for global cooperation and concerted action. Secretary Albright hosted a meeting of female foreign ministers during the UN General Assembly session in September 2000 to discuss the global HIV/AIDS situation and the special needs of women and girls in fighting this disease. A letter signed by the foreign ministers was sent to UN Secretary General Kofi Annan urging more global action to address the AIDS pandemic.
- **Department of the Treasury.** The Department has been out front in providing information on the economic impact of AIDS throughout the U.S. government, to the Congress, and to both donor and developing nations. In addition, the Department has actively pursued four HIV/AIDS related initiatives:
 1. The Secretary and the President have worked vigorously to secure debt relief for Heavily Indebted Poor Countries. The Administration was successful in pushing this initiative at the Cologne G-7/G-8 Summit and in securing \$435 million in FY 2001 for this purpose. These funds will enable poor countries, many in sub-Saharan Africa, to redirect scarce resources from debt service into poverty reduction as well as AIDS prevention and care programs.
 2. The Administration called on the World Bank and other multilateral development banks to dedicate an additional \$400 to \$900 million annually of low-interest loans to prevent infectious diseases such as AIDS and to build effective health care delivery systems. As a result, working with the World Bank, the Administration helped to secure a new \$500 million program of concessional loans for AIDS care and prevention programs in sub-Saharan Africa.
 3. As part of the President's Millennium Vaccine Initiative, the Department continues to work with Congress to pass a new \$1 billion tax credit for sales of vaccines for HIV/AIDS, malaria, and tuberculosis to accelerate their development, production, and distribution.
 4. The Department is working with Congress and the World Bank on implementing the newly authorized World Bank AIDS Trust Fund.
- **Peace Corps.** The Peace Corps launched an initiative designed to train all 2,400 Peace Corps volunteers serving in 25 countries in Africa as AIDS educators and basic care providers.

- **United States Mission to the UN (USUN).** USUN played a critical role in bringing international attention to the threat posed by HIV/AIDS and in formulating the foundation for future international efforts to fight the epidemic. Specifically, under the leadership of the U.S. ambassador to the UN, the first meeting of the UN Security Council in 2000, chaired by Vice President Gore, focused on HIV/AIDS. Partly as a result of that session, the UN Security Council in July passed a resolution determining that HIV/AIDS posed a threat to international peace and security. The UN Security Council also agreed to incorporate explicit language to protect peacekeepers and the communities in which they serve from HIV/AIDS in all future resolutions on peacekeeping.

Further, USUN succeeded in convincing a number of nations of the importance of high-level leadership, international coordination, and shared goals and commitments in winning the battle against HIV/AIDS. To that end, USUN has offered the idea of forming a global coordinating body of Presidential Envoys on AIDS Cooperation (PEACs) from the highest levels of the world's governments. The U.S. appointed its PEAC, Sandra Thurman, in August 2000. The UN General Assembly has also decided to hold a special session on HIV/AIDS in New York, July 25-27, 2001 to create a Declaration of Political Commitment to help turn the corner on global resources and political leadership dedicated to fighting the epidemic.

- **Office of National AIDS Policy.** Central to this broad-based U.S. government response has been the coordination needed to maximize both effectiveness and impact. This coordination function has been supplied by the White House through its Office of National AIDS Policy, and in consultation with the National Security Council, the National Economic Council, and the Office of Management and Budget. In addition, the President established an Intergovernmental Working Group on Global AIDS co-chaired by the Office of National AIDS Policy and the National Security Council.

The LIFE initiative has enabled the U.S. government to leverage enhanced leadership and increased resources from other donor nations as well as other sectors in this global mobilization against AIDS.

As President Clinton said in signing the Global AIDS and Tuberculosis Relief Act of 2000:

“The United States cannot and should not battle AIDS alone. This crisis will require the active engagement of all sectors or all societies working together. Every bilateral donor, every multilateral lending agency, the corporate community, the foundation community, the religious community, and every host government of a developing nation must do its part to provide the leadership and resources necessary to turn this tide. It can and it must be done.”

With this in mind, the President has challenge our G-8 partners and other donor nations to match the significant new investments in global AIDS secured by the U.S. He has also directed all U.S. government representatives to use every opportunity to raise HIV/AIDS in every diplomatic forum and to push for enhanced coordination and cooperation in this global crisis. In May 2000, President Clinton and EU President Antonio Guterres released a bold statement outlining future collaboration between the two in HIV/AIDS, tuberculosis, and malaria in Africa. In July 2000, the President secured agreement from our G-8 partners to increase resources to fight HIV/AIDS

and other leading infectious killers. The President also obtained a commitment from our APEC (Asia Pacific Economic Cooperation) partners. The Administration's efforts at enlisting new allies were not limited to other donor nations but also included a number of private-sector partners. In this spirit, the White House hosted several individual summits for labor, foundation, and religious leaders. A complete calendar of activities related to the LIFE initiative follows:

LIFE Initiative
Key Administration Events
1998-2000

- April 1998 President Clinton and First Lady Hillary Rodham Clinton visit Africa.
- December 1998 President Clinton charges Sandra Thurman, Director of the Office of National AIDS Policy (ONAP), to conduct a fact-finding mission in Africa.
- February 1999 ONAP Director Thurman leads a Presidential delegation to Africa, visiting Uganda, Zimbabwe, Zambia, and South Africa.
- March 1999 The U.S. hosts the first U.S.-Africa Ministerial meeting (Ministers of Trade, Finance and Foreign Affairs). HIV/AIDS is a prominent issue.
- Secretary of State Madeline Albright launches a diplomatic initiative, the “U.S. International Response to HIV/AIDS,” instructing U.S. ambassadors to raise the profile of global HIV/AIDS and encourage political commitment overseas to combat the disease.
- April 1999 ONAP Director Thurman leads a Presidential mission to Uganda, Zambia and South Africa.
- USAID is instrumental in helping to establish the International Partnership against AIDS in Africa.
- U.S.-Southern Africa Development Council Forum highlights HIV/AIDS as part of a high-level agenda in this initial multilateral discussion.
- Under Secretary for Global Affairs Frank E. Loy, and UNAIDS Director Dr. Peter Piot, co-host a briefing for the foreign diplomatic community on the foreign policy implications of the HIV/AIDS pandemic.
- The U.S. negotiates an HIV/AIDS resolution at the UN Human Rights Commission meetings to strengthen international commitments to HIV/AIDS cooperation and to secure greater respect for human rights for persons living with HIV/AIDS.
- June 1999 President Clinton proposes an initiative to link debt relief with health, education, and social needs, with special attention on HIV/AIDS, at the Cologne G-8 meeting.
- July 1999 Vice President Gore launches the LIFE Initiative.
- September 1999 First Lady Hillary Rodham Clinton hosts a meeting with key foundations to encourage involvement in support of HIV/AIDS programs.

- October 1999 Secretary Albright raises HIV/AIDS issues with all heads of state in her meetings during the UN General Assembly.
- Secretary Albright raises HIV/AIDS issues with heads of state during a trip to Africa, encouraging higher priority to HIV/AIDS by national governments.
- Congress approves an additional \$100 million for the fight against HIV/AIDS globally, with an emphasis on Africa.
- November 1999 Secretary Albright opens the UN program to commemorate World AIDS Day at UN headquarters in New York.
- USUN Ambassador Holbrooke travels to Africa and discusses HIV/AIDS foreign policy concerns with African leaders in preparation for the U.S. chairing the UN Security Council.
- December 1999 Secretary Albright raises HIV/AIDS with all heads of state during a trip to Africa.
- First Lady Hillary Rodham Clinton holds a UN conference on the status of AIDS orphans around the world.
- January 2000 A UN Security Council meeting on HIV/AIDS in Africa, chaired by Vice President Gore, initiates greater U.S. commitment to international assistance for HIV/AIDS.
- Secretary of Labor Alexis Herman co-hosts with AFL-CIO President John Sweeney the first U.S.-Africa Trade Union Summit on HIV/AIDS Workplace Education and Prevention.
- February 2000 The National Security Council forms an interagency working group on HIV/AIDS.
- Ambassador Holbrooke joins an interagency briefing of Congressional leaders on HIV/AIDS as a foreign policy issue, focusing on its impact on international peacekeeping efforts.
- March 2000 President Clinton visits India and signs a Joint Statement on HIV/AIDS with Prime Minister Vajpayee.
- Secretary Albright raises the issue of enhanced U.S.-EU cooperation on AIDS and other infectious diseases at the U.S.-EU ministerial meeting.
- May 2000 President Clinton highlights HIV/AIDS in Africa in a major address at the National Summit on Africa.

- President Clinton and EU President Guterres release a joint statement on collaborating on HIV/AIDS, tuberculosis, and malaria at the U.S.-EU Summit.
- June 2000 Secretary of the Treasury Lawrence Summers and Director Thurman visit Africa with HIV/AIDS as an economic issue high on the U.S. agenda.
- July 2000 U.S. scientists and ONAP Director Thurman attend the International AIDS Conference in Durban.
- The U.S. helps pass a resolution on HIV/AIDS and its implications for peacekeeping operations, the first UN Security Council resolution on a health issue.
- The G-8 Summit focuses on HIV/AIDS as a top priority and mobilizes resources from G-8 partners.
- August 2000 President Clinton visits Nigeria and makes HIV/AIDS a key issue.
- President Clinton appoints ONAP Director Thurman as the first Presidential Envoy for AIDS Control.
- Congress passes and President Clinton signs the Global HIV/AIDS and TB Relief Act of 2000.
- September 2000 President Clinton addresses HIV/AIDS as a key issue for the millennium at the UN Millennium Summit.
- At the 55th UN General Assembly in New York, the Secretary of State joins 12 female foreign ministers in sending a letter to UN Secretary General Annan proclaiming their joint resolve to combat the global scourge of HIV/AIDS.
- October 2000 Congress approves large increases in HIV/AIDS funding for USAID and debt relief, pursuant to President Clinton's budget request.
- November 2000 First Lady Hillary Rodham Clinton visits AIDS programs in Vietnam.
- December 2000 The White House hosts a Religious Leaders' Summit on the occasion of World AIDS Day 2000. President Clinton delivers an AIDS address at Howard University.
- The Clinton Administration works with Congress to advocate a strategy for HIV/AIDS funding pending in the Labor-HHS appropriations bill.

VII. Challenges for the Future

“The Clinton Administration has put the global AIDS issue on the map – and has positioned the United States as a leader in this fight. We have made great strides – but we have a long way to go. As a move toward a new Administration, a new Congress, and the new millennium – America must continue to lead this charge. The eyes of the world are upon us.”

Terje Anderson
Executive Director, National Association of People with AIDS

Resources

At this juncture, the good news is that we know what works. What we need now are the resources required to bring these proven programs and strategies to a scale that matches the magnitude of this ever-expanding pandemic. Over the past few years, the U.S. government, as the largest global AIDS donor, has secured significant funding increases and has leveraged others to do the same. However, much more remains to be done. UNAIDS has said that it will take an investment of at least \$3 billion to put an effective HIV prevention and basic AIDS care program in place in Africa alone. Last year, collective spending was only one tenth that amount, approximately half of which came from the U.S. In addition, \$3 billion is also required to put a similar program in place for the rest of the world, only half of which is currently available. As President Clinton said before the United Nations Security Council at the Millennium Summit in September, “we must join together to help close this gap.” In the years ahead, we must work with Congress, the private sector, and the global community to close the gap between rhetoric and real action, and between the resources needed and those currently being invested.

Leadership

The U.S. government-wide effort mobilized through the LIFE initiative has played a major role in elevating the global AIDS pandemic high on the diplomatic radar screen. But it is vital to remember that we are at the beginning and not the end of this pandemic. Together, we must join forces in the battle against AIDS as we would in the face of any other disaster where hundreds of millions of lives hang in the balance. Now, more than ever, continued moral authority and steadfast leadership are desperately needed. There are no simple solutions or quick fixes. Winning the war on AIDS means keeping the U.S. government as an outspoken, out-front leader in this fight. Not just this year or next, but for the long haul until our work is done.

The pages of history reveal moments in time when the global community came together in the face of seemingly insurmountable odds and changed the world. Time and again, we have borne witness to what can be accomplished by those who refuse to give up or give in. Together we must reach for one of those moments again now, or we will surely pay the price later.